STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 15,630
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare not to provide coverage under the Vermont Health Access Plan (VHAP) for medical services rendered in December, 1997, and January, 1998. The issue is whether misinformation given to the petitioner by the managed care company that had enrolled VHAP participants binds the Department to cover services during a period in which the petitioner was ineligible for VHAP. The following facts are not in dispute.

FINDINGS OF FACT

1. The petitioner and her husband were covered by VHAP through most of 1997.[1] On November 1, 1997, the petitioner and her husband were scheduled to have their medical coverage shifted to CHP, a managed care company with whom the Department had contracted to provide health coverage to recipients of VHAP. The Department notified the petitioner of that impending shift in a timely manner.

2. On October 16, 1997, the Department notified the petitioner that based on an increase in income she and her

[1]The petitioner's child received coverage under the Department's Dr. Dynasaur program.

husband would no longer be eligible for VHAP as of October 26, 1997.[2] The petitioner did not appeal this decision, and she still takes no issue with it. The notice sent by the Department included the conspicuous message: "IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, CALL HEALTH ACCESS ELIGIBILITY UNIT", which was followed by a toll free telephone number.

3. Prior to November 1, 1997, a company called Maximus contracted with the Department to administer the VHAP program. The Department's records show that Maximus notified CHP on October 15, 1998, that the petitioner and her husband had been "disenrolled" from VHAP.

4. In early November, 1997, CHP sent the petitioner a "welcome packet", which included identification cards for the petitioner and her husband, describing CHP coverage and procedures. Having just received her termination notice from VHAP, the petitioner was confused by this, and she called CHP to inquire if she was covered. The petitioner maintains that CHP told her she was covered. The petitioner did not call the Department (i.e Health Access) to verify what CHP had told her.

5. In December, 1997, the petitioner's husband had intestinal problems on a weekend day. They called their family doctor and told him that they had CHP. He advised them to go to the hospital emergency room and that this

[2]Their child remained eligible for Dr. Dynasaur.

would be covered under their CHP.

6. The petitioner maintains that if her husband knew he wasn't covered for this visit he would have "toughed it out" and seen his doctor for a much-less-costly office visit the following Monday. The emergency room visit cost $444.

7. In early January the petitioner called CHP again because she had an annual OB/GYN checkup scheduled. She maintains that CHP again told her she was covered. Again, the petitioner did not contact the Department.

8. In February, 1998, the petitioner received the bill for her husband's emergency room visit indicating that it had not been paid by insurance. The petitioner called CHP and was told that CHP had not closed out her coverage until January 5, 1998, but had "backdated" the closure to November 1, 1997.

9. The petitioner took an appeal through CHP, but its final decision is that it will not cover either the emergency room visit or the OB/GYN appointment because the petitioner was not eligible for VHAP during this period.[3] The petitioner then filed the instant appeal.

10. The Department acknowledges that it appears that CHP made a mistake in failing to disenroll the petitioner in a timely manner, and then giving the petitioner misinformation about her coverage. The Department

[3]To complicate matters, the petitioner maintains that CHP did cover a pharmacy bill the petitioner incurred on December 9, 1997.

maintains, however, that any liability for this mistake rests with CHP, not the Department.

11. After the petitioner received her VHAP termination notice from the Department in October, 1997, all the petitioner's communication was with CHP.

ORDER

The Department's decision is affirmed.

REASONS

Medicaid Manual ə M103.26 provides as follows:

> Appeals of Managed Health Care Plan Decisions
>
> Recipients enrolled in managed care plans have the right to appeal medical care decisions made by the managed health care plans based on medical/clinical necessity determinations. Although medical/clinical determinations will be made by the medical director of the managed care plan, ultimate authority on such determinations lies with the state.
>
> Recipients first must seek remedy of a medical care decision through the managed health care plan's formal grievance process. The managed health care plan may take up to 15 days to seek resolution of a complaint not related to medical care. The decision of the managed health care plan shall be in writing and shall be sent to the recipient and to the Office of Vermont Health Access.

Under the above provision the Department and, ultimately, the Board have final authority over coverage decisions made by CHP. In this case the petitioner concedes that she was not financially eligible for CHP-VHAP coverage

after October 26, 1997. The petitioner maintains, however, that CHP misled her into believing she and her husband were covered after that time, and that this misinformation caused her husband to seek a more-costly type of medical treatment that he otherwise would not have. The issue is whether these facts would support a conclusion that the Department is estopped by the actions of CHP from denying coverage to the petitioner for this expense.

The four essential elements of estoppel are: (1) the party to be estopped must know the facts; (2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting estoppel has a right to believe it is so intended; (3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped. Stevens v. DSW, 159 Vt. 408, 421; Burlington Fire Fighter's Association. v. City of Burlington, 149 Vt. 293, 299 (1988).

Applying these elements to the facts herein, and putting aside the (far from clear) question of the Department's liability for the actions of its contractee (CHP), it must be concluded that the petitioner fails the third and fourth tests (supra) necessary for estoppel to lie--i.e., it cannot be found that she was "ignorant of the true facts" and that she "relied to her detriment" on the misinformation she received from CHP.

Regarding the third test, the petitioner admits that she received a notice from the Department terminating her and her husband's coverage under VHAP and that she understood the reason why--i.e., that she and her husband were over income. The notice included a toll free number to call if the petitioner had any questions about her eligibility. Despite this information, when the petitioner was understandably confused upon receiving her welcome packet from CHP, she only called CHP with her question about coverage. When CHP told her she was eligible, the petitioner made no attempt to reconcile the conflicting information she had received.

Based on the unequivocal notice of termination the petitioner had received, and the clear instructions to call Health Access if she had any questions, it must be concluded that the petitioner did not make an adequate effort to learn the "true facts" of her eligibility, even after talking with CHP. Thus, the third element of estoppel is not met.

It must also be concluded that the petitioner's alleged "detrimental reliance" on the misinformation she received from CHP is too uncertain and speculative to meet the fourth element of the legal test set forth above. Assuming that one credits the petitioner's assertion (made ex post facto) that her husband, if he knew he wasn't covered at the time, would have waited two days to see his family doctor rather than go to the emergency room for his intestinal distress,

it is not at all clear that the petitioner might not have incurred the same, or more, expense if her husband's condition had gone untreated over the weekend. Although the petitioner maintains her husband would have "toughed it out", the fact remains that his doctor advised him to seek this emergency treatment. It is simply not known whether his condition would have worsened if he had avoided or delayed going to the hospital, which might well have necessitated similar, or even more expensive, emergency treatment that he would not, or could not, have eschewed.

As for the petitioner's OB/GYN visit in January, 1998, the petitioner does not maintain that she would not have gone to this appointment if she knew it was not covered by insurance. Thus, it cannot be concluded that the petitioner detrimentally relied of misinformation from CHP in incurring this expense.

Inasmuch as the elements of estoppel are not met, and there being no issue that the petitioner was, in fact, ineligible for VHAP during the period in question, the Department's decision is affirmed. 3 V.S.A. ə 3091(d) and Fair Hearing Rule No. 17.

# # #